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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name:_____

Birth Date: _____ Social Security Number: _____

I HEREBY REQUEST AND AUTHORIZE CHIP ABERNATHY, LPC:

CHECK ALL THAT APPLY: [ ] TO RELEASE TO (Charges May Apply) [ ] TO REQUEST FROM

Name: _____

Address: _____

(Email) _____ (PHONE):

(FAX):

THE FOLLOWING INFORMATION
CHECK APPROPRIATE AREAS TO BE RELEASED – YOU MUST BE SPECIFIC

[ ] PATIENT INFORMATION FORM
[ ] INFORMED CONSENT FORM
[ ] VERBAL/ELECTRONIC COMMUNICATION
[ ] CLINICAL ASSESSMENT (DATA BASE)
[ ] LETTER RE: PROGRESS/RECOMMENDATIONS
[ ] PROGRESS NOTES
[ ] TREATMENT PLAN
[ ] RELEASE OF INFORMATION FORMS
[ ] CONTINUING CARE PLAN
[ ] CONSULTATIONS
[ ] OTHER (PLEASE SPECIFY): _____

FOR THE PURPOSE OF: (MUST BE COMPLETED) ( ) CONTINUED TREATMENT
( ) OTHER: _____

I AGREE TO INDEMNIFY AND HOLD HARMLESS CHIP ABERNATHY, LPC AND STAFF/DESIGNEES FROM ALL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION HEREIN REQUESTED.

MEDICAL RECORDS FREQUENTLY CONTAIN INFORMATION THAT MAY BE PRIVILEGED AND/OR CONFIDENTIAL. THE PATIENT, PATIENT'S FAMILY AND / OR STAFF MAY FURNISH INFORMATION. IF, IN THE JUDGMENT OF CHIP ABERNATHY, LPC, DISCLOSURE OF THE PRIVILEGED/ CONFIDENTIAL INFORMATION WILL BE HARMFUL TO THE PATIENT, RELEASE OF SUCH INFORMATION MAY BE WITHHELD IN ACCORDANCE WITH SPECIFIC STATE AND FEDERAL REGULATIONS. RECORDS RELEASED MAY CONTAIN ALCOHOL AND DRUG TREATMENT INFORMATION, PATIENT PHOTOGRAPHS, AIDS/HIV OR PSYCHIATRIC/PSYCHOLOGICAL OR MENTAL HEALTH PRIVILEGED OR CONFIDENTIAL INFORMATION. CERTAIN COMMUNICATIONS ARE PRIVILEGED AND NOT SUBJECT TO RELEASE WITHOUT YOUR CONSENT UNDER STATE AND/OR FEDERAL LAW.

AFTER GIVING DUE CONSIDERATION TO THE ABOVE STATEMENT, I AUTHORIZE CHIP ABERNATHY, LPC AND/OR MEMBERS OF HIS STAFF OR DESIGNEES TO FURNISH INFORMATION, INCLUDING CELLULAR TELEPHONE, ELECTRONIC, PHOTOSTATIC, EMAILED OR FAXED COPIES OF MY MEDICAL RECORD, INCLUDING MATTERS PRIVILEGED UNDER THE LAWS OF THE STATE OF GEORGIA, AND APPLICABLE FEDERAL LAWS AND REGULATIONS INCLUDING BUT NOT LIMITED TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), TO THE ABOVE ORGANIZTION/INDIVIDUAL, OR TO ITS AGENTS. IN ALL OF THESE INSTANCES, CONFIDENTIALITY WILL BE PROTECTED AS WELL AS POSSIBLE, BUT IS LIMITED DUE TO THE RISK OF THE INFORMATION BEING OVERHEARD OR ENDING UP IN THE WRONG HANDS. PRECAUSTIONS WILL BE TAKEN WHEREVER POSSIBLE.

I UNDERSTAND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION, IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREOF, AND REMAINS VALID FROM THE DATE OF MY SIGNATURE, UNLESS I SPECIFY A TERMINATION DATE HERE: _____ .

_____ _____
DATE SIGNED PATIENT SIGNATURE

_____ _____
WITNESS SIGNATURE (LEGAL GUARDIAN IF APPLICABLE)/ RELATIONSHIP

PROHIBITION OF REDISCLOSURE: THIS INFORMATION MAY BE PROTECTED BY FEDERAL REGULATION (42 CFR PART 2), WHICH PROHIBITS FURTHER DISCLOSURE